

AN ANALYSIS OF FAMILY PLANNING CONTENT IN HIV/AIDS, VCT, AND PMTCT POLICIES IN 16 COUNTRIES

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Executive Summary

Despite some attempts to integrate family planning with sexually transmitted infection (STI) and HIV/AIDS services, policies and programs continue to treat them as unrelated areas of intervention. Furthermore, international attention to the HIV/AIDS pandemic has overshadowed attention to family planning, particularly in Africa where the HIV/AIDS epidemic is most acute. Yet family planning is closely related to two components of HIV/AIDS services: prevention of mother-to-child transmission (PMTCT) and voluntary counseling and testing (VCT). Is there a role for family planning in the context of HIV/AIDS programs?

This paper analyzes how international guidelines, national HIV/AIDS policies and PMTCT and VCT policies have addressed family planning in 16 high-HIV prevalence countries. It also describes major gaps in the various countries' policy environment.

- All but one of the international policy guidelines on VCT and PMTCT explicitly address family planning. However, the focus on family planning is primarily through the provision of information on contraceptives and/or referral to family planning services.
- Slightly more than half of the 16 national HIV/AIDS policies and guidelines reviewed here made reference to family planning. Nine policies refer to family planning, and four refer to it only in terms of equipping family planning clinics with HIV facilities or preventing mother-to-child transmission of HIV/AIDS.
- Six of the nine national VCT policies and guidelines make some reference to family planning, mostly as a topic to be mentioned in counseling and as a service for referral.
- All five national and two regional PMTCT guidelines refer to family planning directly, and one cites specific examples of contraceptive methods.

Considering that more than three-quarters of the policies reviewed here mention family planning, the findings offer encouragement. Nonetheless, for programs to incorporate family planning effectively into VCT and PMTCT, their settings, policies, and operational guidelines need to address clearly the importance of family planning in HIV prevention and specify how family planning should be addressed in HIV prevention activities. Major gaps in the inclusion of family planning in VCT and PMTCT services point to the need for (1) broader-based participation in the policy development process, (2) stronger linkages with maternal and child health/family planning departments, (3) a greater emphasis on human and reproductive rights and gender, (4) a sharper focus on fertility choices for HIV-positive women, (5) an emphasis on HIV counseling sessions as the appropriate time to mention family planning, (6) an emphasis on dual protection and dual method use, (7) further investment in and stronger linkages to care and support programs, (8) consideration of operational challenges in existing VCT and PMTCT services, and (9) the recognition of adolescents as a specific target group.

Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
MCH	Maternal and child health
MTCT	Mother-to-child transmission
PLWHA, PLHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
SADC	South African Development Community
STI	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	United Nations Global Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
VCT	Voluntary counseling and testing
WHO	World Health Organization

Introduction

Despite some attempts to integrate family planning with sexually transmitted infection (STI) and HIV/AIDS services, policies and programs continue to treat them as unrelated areas of intervention. Furthermore, international attention to the HIV/AIDS pandemic has overshadowed attention to family planning, particularly in Africa where the HIV/AIDS epidemic is most acute. Nonetheless, family planning services are closely related to two types of HIV/AIDS services: prevention of mother-to-child transmission (PMTCT) and voluntary counseling and testing (VCT). What is the role for family planning in the context of HIV/AIDS programs?

Considered in the broader context of reproductive health, more than 180 countries have affirmed the right of individuals and couples to access to the means to achieving good reproductive health, including access to family planning and access to STI and HIV/AIDS services. The Program of Action, from the International Conference on Population and Development (ICPD), defines reproductive health as follows:

Reproductive health is a state of complete physical, mental and social well-being. . . in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services which contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (ICPD, 1994).

It is important that family planning information and services be provided in the context of HIV/AIDS programs for several reasons. In many countries, HIV is primarily sexually transmitted, and the majority of infections occur during the reproductive ages. Women seeking PMTCT services are both sexually active and fertile. Obtaining these services offers the woman and her partner options to either practice birth spacing which can reduce infant, child, and maternal mortality rates or avoid future pregnancies thereby avoiding transmission of HIV to an infant. In addition, limiting the number of births may result in fewer orphans and vulnerable children. Sexually active VCT clients may also be at risk for an unintended pregnancy. Counseling for HIV/AIDS is an opportune time to discuss family planning and high-risk fertility behavior. Clients receiving antiretroviral therapy (ARV) may also have a need for family planning since a large percentage of these clients will be of reproductive age.

In a single, random unprotected sex act, the probability of pregnancy is higher than the probability of HIV infection. The probability of pregnancy is 3.5 percent (Bongaarts and Potter, 1983) while the probability of HIV infection is 0.1 percent for male-to-female transmission and 0.2 percent for female-to-male transmission (Futures Group, 2003). Yet, HIV/AIDS service delivery settings typically focus on condoms as a method for preventing the spread of STIs/HIV and fail to acknowledge the contraceptive benefits of condoms. Similarly, family planning clinic settings may stress contraceptive use without discussing the prevention of STIs or HIV. Sexually active men and women receiving information on either family planning or STI/HIV prevention should have access to information and services to help

prevent *all* unintended outcomes of unprotected sex, including unplanned pregnancies and STIs/HIV. Access to family planning information and services linked with HIV/AIDS services may enable sexually active persons to make informed decisions about their reproductive and sexual health and lead to reductions in both unintended pregnancies and STIs/HIV.

VCT and PMTCT programs have become integral components of comprehensive HIV/AIDS prevention and care services, particularly in countries with high HIV prevalence. In fact, VCT and PMTCT are two HIV/AIDS-oriented services that could be easily incorporated into family planning services. Many VCT and PMTCT programs started as pilot programs, but the urgency of the AIDS pandemic has led to the need for rapidly scaling up programs to the national level (UNICEF et al., 2000). Some countries have made laudable efforts in formulating policies and guidelines to implement VCT and PMTCT programs, whereas others are in the early stages of policy development.

As policies are developed, they present an excellent opportunity to ensure that supporting guidelines emphasize the importance of condoms as a means of protection against both STIs/HIV and conception (dual protection¹). Such policies should also stress the importance of using condoms in conjunction with another contraceptive method, including pills, injectables, and IUDs (dual method use), to prevent both unintended pregnancies and STIs. At the operational level, service delivery guidelines, protocols, and tools are needed to address explicitly how family planning can be integrated into new or existing services while ensuring that adequate support, including human and financial resources, are available to make integration work. Guidelines should carefully address counseling and emphasize the dual protection afforded by condoms as well as the need for high-quality counseling services, refresher training, and the institution of standard counseling protocols. Further, adequate dissemination of protocols is critical to ensure that providers know what is expected of them. Legislative guidelines need to be reviewed and adapted as necessary to ensure that providers can legally provide necessary services. Technical guidelines for training staff should be adapted to train staff in both reproductive health/family planning and STI/HIV treatment and prevention. Supervision and follow-up among service providers are essential to ensure that guidelines are implemented.

This paper analyzes how international guidelines and national HIV/AIDS, VCT, and PMTCT policies in 16 high-prevalence HIV countries address family planning. It then describes significant gaps in the countries' policy environment. In addition, the analysis sets the stage for in-depth research to be conducted by POLICY in Jamaica, South Africa, and Uganda in 2003–2004. The in-depth country studies will investigate barriers to the provision of family planning in conjunction with VCT and PMTCT services, the extent to which family planning services have been and can be integrated into VCT and PMTCT programs and services, and the specific needs of service providers and clients in providing and accessing such services.

¹ Dual protection, according to the 2003 USAID guidelines, not only refers to the use of a condom to protect against unintended pregnancy and HIV/STIs. It also includes dual method use, mutual monogamy, use of an effective contraceptive method, and abstinence and/or delay of sexual debut.

Methodology

The analysis is based on a review of policies and guidelines identified primarily through a search of the HIV/AIDS Policy Compendium maintained by the POLICY Project. The compendium currently includes 117 policy documents and is updated regularly. The analysis focuses on international guidelines and on policies and guidelines in 14 countries in sub-Saharan Africa, and in Thailand and Jamaica.



Analysis of Family Planning Content in International VCT and PMTCT Guidelines

Based on a review of 12 documents, this section describes the family planning content in international VCT and PMTCT guidelines. The first two documents are policy statements; the remaining 10 documents are practical guidance and recommendations for stakeholders to consider in mounting an effective response to HIV/AIDS. The specific references to the provision of family planning information and services are described below.

1. UNAIDS Policy on HIV Testing and Counseling (1997)

The UNAIDS *Policy on HIV Testing and Counseling* (1997), which encourages countries to establish national HIV/AIDS policies, recommends that countries carefully consider increasing women's voluntary access to VCT services. With respect to family planning, the guidelines state the following:

Women should be offered information on reproductive and infant feeding options and on the use of antiretroviral treatment to reduce the risk of mother-to-child (vertical) HIV transmission.

The policy does not explicitly address referral to appropriate services.

2. UNAIDS/UNICEF/WHO HIV and Infant Feeding: A Policy Statement (1997)

The UNAIDS/UNICEF/WHO *HIV and Infant Feeding: A Policy Statement* (1997), as cited in *HIV and Infant Feeding: Guidelines for Decision-makers*, includes a reference to "safer sex" but, as noted below, does not explicitly use the phrase "family planning" in the section on preventing HIV infection in women:

Immediate practical measures should include ensuring access to information about HIV/AIDS and its prevention, promotion of safer sex including the use of condoms, and adequate treatment of sexually transmitted diseases which significantly increase the risk of HIV transmission.

3. UNAIDS/UNICEF/WHO HIV and Infant Feeding: Guidelines for Decision-makers (1998)

The UNAIDS/UNICEF/WHO *HIV and Infant Feeding: Guidelines for Decision-makers* (1998) "aim. . .not to recommend specific policies, but rather to discuss issues that need to be considered, to give background information and to highlight areas of special concern on which policy decisions need to be made locally." The guidelines make more explicit references to the importance of family planning vis-à-vis PMTCT than the UNAIDS MTCT Technical Update. Specifically, the guidelines focus on increasing access to both VCT and family planning information and services for all women, ensuring that nonbreastfeeding mothers have access to family planning, and strengthening existing services to meet the needs of HIV-positive women. Specific references to family planning include the following:

Develop and promote voluntary and confidential counseling and HIV testing services, which are committed to informed consent and protection of confidentiality. A policy on infant feeding and HIV, which is based on meeting the needs of individual mothers and infants, requires that women know their HIV status. Improving access to counseling and testing for all women and their partners in antenatal care, family planning, and all other appropriate points in the health

services is necessary to implement interventions to reduce MTCT, such as infant feeding options and antiretroviral drug treatment. (page 7)²

Strengthen family planning provision to give women the option of avoiding pregnancy if they wish.

Within the context of the value of breastfeeding (a text box), a reference to family planning appears as follows:

Family planning. Breastfeeding delays the return of a woman's fertility. If a woman does not breastfeed, she is at increased risk of an early pregnancy. It is important to ensure that she has access to appropriate contraceptives within six weeks of delivery. (page 8)

Prevention of MTCT requires strengthened maternity and family planning services, with increased access to antenatal care, counseling and testing for HIV, antiretroviral drugs and alternatives to breastfeeding. (page 9)

The guidelines urge decision makers to consider the following:

What are the implications for family planning services? A policy recommendation that HIV-infected mothers be counseled about considering not breastfeeding can have major implications for birth spacing. HIV-infected mothers who do not breastfeed are deprived of protection from lactational amenorrhea. If they do not use an appropriate form of family planning, they may have a shorter interval between births with adverse consequences for their own health. Ultimately, a larger number of potentially HIV-infected children will be born and will need to be cared for. Family planning and information and services need to be made readily available to mothers and their partners.

In relation to information, education, and communication (IEC) campaigns on HIV and infant breastfeeding, it is important "to reinforce messages about the benefits of family planning and contraception." (page 15) In terms of policy implementation, the guidelines state the following:

After assessing the situation, priority tasks for implementing policy on HIV and infant feeding are:
... assess additional family planning and contraceptive needs for non-breastfeeding women, and ensure that supplies of and access to condoms is adequate. (page 17)

Apart from the *HIV and Infant Feeding Policy Statement*, UNAIDS has not developed a PMTCT policy, although it does publish the "Best Practice Collection," which includes guiding principles for VCT and PMTCT that are not explicitly labeled "policies" or "guidelines." Drawing on effective policies, approaches, and strategies implemented around the world, the documents in the collection provide policymakers and program managers with suggestions on important program areas to be considered when establishing VCT or PMTCT services. Therefore, for purposes of the present analysis, several documents in the Best Practice Collection are considered "international guidance."

4. UNAIDS Mother to Child Transmission of HIV: A Technical Update (1998)

The UNAIDS Best Practice Collection's *Mother to Child Transmission of HIV: A Technical Update* (1998) suggests that one component of a successful response to MTCT is a link to family planning programs:

² Page numbers refer to the page in the policy document containing the referent text.

All women and men, irrespective of their HIV status, have the right to determine the course of their reproductive life and health, and to have access to information and services that allow them to protect their own and their family's health. Links between HIV testing programmes and family planning services must be strengthened in order for HIV-infected women and their partners to make informed choices regarding their future reproductive life. One specific point is that breastfeeding has a birth-spacing effect that will disappear (and should be replaced) if the woman chooses not to breastfeed her infant. Failing to address this issue through counseling and education can result in more HIV-positive infants being borne than would otherwise be the case.

5. UNAIDS Counseling and Voluntary Testing for Pregnant Women in High HIV Prevalence Countries: Elements and Issues (2001)

The more recently published UNAIDS Best Practice Collection's *Counseling and Voluntary Testing for Pregnant Women in High HIV Prevalence Countries: Elements and Issues* (2001) aims "to provide guidance on the counseling and HIV testing for managers of antenatal clinics and other pregnancy-related services, whether they are public, private or non-profit. [The document] may also be used as a basis for discussion in developing a national policy in this increasingly important area." The publication mentions several times that family planning is essential to both pre- and post-counseling in antenatal care (ANC) sessions. It also discusses the involvement of men relative to fertility decisions. Specifically, the guidance suggests the following:

It is not necessary to wait until the full range of services is on offer before integrating HIV-related information, counseling and voluntary HIV testing into routine pregnancy care. At the very least, women can be provided with information about reducing their and their partner's exposure to HIV infection, and about avoiding unwanted pregnancies. (page 6)

By way of summary, pre-test information and counseling should address the following:

- The implications of a negative test result, including information on how to remain HIV-negative, promotion of breastfeeding and family planning.
- The implications of a positive test result, including costs and benefits of potential interventions, promotion of safe infant feeding practices and family planning, a discussion of their own, their family's and their child's survival and the possible exposure to stigma. (page 7)

Men attending reproductive health services should receive counseling about HIV transmission and prevention. This information should include a discussion about transmission from mother to child. Counseling about fertility decisions and contraceptive services should be given. (page 7)

Helping HIV-positive couples to avoid unwanted pregnancy will also cut the likely number of new infections. (page 8)

Since the potential benefits of knowing one's HIV status in the context of childbearing are greater for HIV-infected women, counselors should take particular care to explain the benefits to women, whose self-assessment suggests that they are at elevated risk of being HIV-infected. (page 8)

By way of summary, post-test information and counseling for HIV-negative women should focus on the following:

When a partner is infected, or when his serological status is not known, the importance of prevention information and counseling is greater still. Information on where to get condoms and other contraceptive means should be given. (page 10)

Post-test information and counseling for HIV-positive women should advise the following:

While women and couples should be free to make their own decision about child-bearing, counselors should ensure that women are aware of the risks inherent in any future pregnancies, as well as the risk of passing on the virus during unprotected sex. (page 12)

Women who choose to avoid pregnancy in the future because of their HIV infection should be referred to family planning services. Women who choose two years of replacement feeding should also receive advice on contraception to replace the birth-spacing effect of breastfeeding. If they choose to bear more children, they should be encouraged to delay the pregnancy for at least two years. (page 12)

6. WHO Voluntary Counseling and Testing for HIV Infection in Antenatal Care: Practical Considerations for Implementation (1999)

The World Health Organization's *Voluntary Counseling and Testing for HIV Infection in Antenatal Care: Practical Considerations for Implementation* (1999) notes the importance of family planning counseling as an essential component in the continuum of care for women not only during and after pregnancy but also with respect to several aspects of program management, such as training and monitoring and evaluation.

First, the document highlights family planning, as follows, as a component in the comprehensive care of pregnant women:

In relation to the antenatal setting, [VCT] is the entry point for comprehensive, long-term care and support of pregnant women, including clinical care such as treatment and prevention of common HIV-related illnesses, including interventions for the prevention of mother to child transmission of HIV, education for prevention of HIV/STI infection, and infant feeding support and family planning including counseling on continuation of current pregnancy and access to safe abortion where this is legal. (page 3)

The publication points to referral as one of the counselor's most important functions and goes on to mention specifically that family planning is an element of care for all women regardless of HIV test results.

The guidelines note that staff working in antenatal clinics offering VCT and PMTCT services will need to be adequately trained in all elements of care, including family planning:

[Health care workers] will need to acquire new skills in order to be able to counsel for and administer ARV treatment or other interventions to reduce MTCT, for prevention of sexual transmission of HIV, for family planning, and for infant feeding options. (page 6)

Regarding interventions, the guidance offers the following:

If ARV treatments to prevent MTCT are being offered, detailed explanations, monitoring and follow-up are particularly important as the procedure is complex and involves a number of different services including family planning and infant feeding support. (page 11)

Whatever the result of the HIV test, safer sex counseling must be provided to women in the antenatal setting If they are unaware of their partner's HIV status or feel that they may be at

risk from HIV infection, they should encourage their partner to use condoms. When appropriate, partners should be involved in safer sex decision and couples should be encouraged to be tested together. (page 11)

The document cites family planning counseling as an essential element of HIV/AIDS counseling for ANC as follows:

Family planning should be discussed and provided, for women who decide to carry through their pregnancy, in the postnatal period. This is especially important if women choose not to breastfeed as they may have planned to rely on prolonged breastfeeding for infant spacing and will lose this benefit. Women in early pregnancy who have a confirmed positive result should be counseled on continuation of the pregnancy and referred to appropriate services. (page 12)

In terms of appropriate venues for VCT, the guidelines suggest that antenatal clinic VCT sites have the advantage of offering support and referral services for family planning. (page 15)

Planning for antenatal VCT services involves several steps, including the development of a workplan. The guidance suggests the following:

Procedures for VCT, for MTCT interventions, for referral to related services need to be defined, staff need to be trained to apply them, and job descriptions modified to ensure that their additional responsibilities are formally recognized by institutional authorities. The information must be made available to all health workers in an accessible and useful format such as a list of “who does what” in HIV care, antenatal care, family planning, infant feeding support, etc., in the local area.. (page 21)

Monitoring and evaluation should include “long-term follow up of women and children (coping, safer sex practices, use of family planning methods/services, and morbidity and mortality of children. . . .” (page 25)

7. WHO *New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications: Conclusions and Recommendations* (2001); WHO Technical Consultation on Behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV

In October 2000, the World Health Organization convened a Technical Consultation on behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV and, as an outcome, produced the guidance entitled *New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications: Conclusions and Recommendations* (2001). The document provides recommendations on a variety of topics, including antiretroviral therapies, risks of breastfeeding and replacement feeding, cessation of breastfeeding, infant feeding counseling, breast health, and maternal health. The guidance mentions family planning in the context of maternal health and makes the following recommendation:

HIV infected women should have access to information, follow-up clinical care and support, including family planning services and nutritional support. Family planning services are particularly important for HIV-infected women who are not breastfeeding. (page 10)

8. CDC Revised Guidelines for HIV Counseling, Testing, and Referral (2001)

Although the Centers for Disease Control and Prevention (CDC) *Revised Guidelines for HIV Counseling, Testing, and Referral* (2001) are primarily geared to service providers and policymakers in the United States, they are nevertheless applicable to the developing country context. The guidelines discuss HIV referral and identify “Typical Referral Needs.” In addition to mentioning services such as medical evaluation, care and treatment, legal services, and STI screening and care, the document mentions referrals to reproductive health services as noted here:

Reproductive health services: Female clients who are pregnant or of childbearing age should receive or be referred to reproductive health services. HIV-infected pregnant women should be referred to providers who can provide prevention counseling and education, initiate medical therapy to prevent perinatal transmission, and provide appropriate care based on established treatment guidelines.

9. CDC Revised Recommendations for HIV Screening of Pregnant Women (2001)

The CDC has updated its 1995 guidelines and now terms them *Revised Recommendations for HIV Screening of Pregnant Women* (2001). The recommendations mention family planning under “Recommendations for HIV-infected Pregnant Women” as follows:

Health care providers should thoroughly assess the prevention service needs of HIV-infected women (e.g., substance abuse, STI treatment, partner referral, or family planning services) and develop a plan to promote access to and use of these services.

10. USAID *Prevention of Mother-to-Child Transmission of HIV in Africa: Practical Guidance for Programs* (2001), prepared by the SARA Project

The SARA Project (USAID) has developed *Prevention of Mother-to-Child Transmission of HIV in Africa: Practical Guidance for Programs* (2001). The guidance is intended to provide policymakers and program managers with information on core MTCT interventions to use in both policy dialogue and the development of national strategies to address MTCT prevention. One of the core interventions is “family planning counseling and services that are linked to VCT.” Activities for family planning counseling and services described in the guide include the following:

- Training family planning workers in HIV/AIDS, MTCT, and contraceptive issues related to HIV infection;
- Establishing referral links between VCT and family planning counseling services;
- Promoting the use of barrier methods for prevention of STIs/HIV;
- Diagnosing and treating STIs;
- Providing additional contraceptives as necessary;
- Conducting formative research on reproductive choice and decision making in relation to HIV infection;
- Strengthening family planning counseling and service provision in antenatal and postpartum services;
- Promoting voluntary family planning as an effective MTCT intervention for HIV-infected women; and
- Improving obstetric practices through safe motherhood programs.

11. Model Guidelines for Voluntary Counseling and Testing: A SADC Priority Policy Guideline Document (2002)

In June 2002, the South African Development Community (SADC) developed model guidelines for VCT. The guidelines are meant to serve as a resource for countries establishing national guidelines and programs. They mention family planning as one of the six essential components of a comprehensive VCT program as follows:

- **Structured systems for referral to relevant prevention, treatment, and support services** for prevention and treatment of syphilis and other STIs; prevention, screening and treatment of TB; family planning services; maternal and child health services; legal assistance; post-test support groups; treatment of HIV-related illnesses; and hospital and home-based care.
- **Service plans should include access to affiliated essential services through development and support of linkages to other sectors and referral networks** for both HIV-positive and HIV-negative clients. VCT sites should be established concurrently with integration into affiliated services to provide a continuum of care and support for as many clients as feasible. There are multiple levels of linkages—regional, national, district and site—necessary to create an enabling environment for VCT services and to ensure coordinated implementation. In addition to developing these various levels of referral networks—among medical, psychosocial, community- and home-based care and support services—it is imperative that VCT service plans include direct assistance to clients seeking and complying with these services. Affiliated services include: psychological and social support; palliative care; treatment for pneumonia, candidiasis, pulmonary TB, and STIs, nutritional counseling, family planning, cotrimoxazole prophylaxis (for the prevention of several secondary bacterial and parasitic infections in PLWHA), and facilitation of other community activities that mitigate the impact of HIV/AIDS. This will require the establishment of procedures for follow up and case management of clients.

The guidelines designate several guiding principles for effective VCT, including the following:

Couple counseling is recommended, since it has been shown to effectively help couples make informed decisions about sexual relationships, marriage, and family planning/pregnancy and to promote behavior change.

The model guidelines also provide operational guidance, as follows, to “inform the design, management, and implementation of VCT service delivery systems”:

Procedures to ensure confidential referrals.

Referral systems increase the responsibility for maintaining “shared confidentiality” of client information among diverse service providers. Yet these systems are critical to ensure that VCT services are integrated within a spectrum of other counseling, medical treatment, and preventive care services and that these array of services are streamlined for clients in need. . . . Key services that should be established within any referral network include: STI prevention and treatment; TB prevention and treatment; family planning services; treatment for HIV-related illnesses (i.e., “opportunistic infections”).

The guidance for monitoring and evaluation cites the need to collect data on the following:

Effectiveness of referrals systems (i.e., number and types of services available, number of referrals made, number of referrals received, number of follow ups required, etc.).

“Safer sex negotiation” is mentioned in post-test counseling for all clients receiving test results.

The Post-test Counseling Guidelines for a Client with an HIV Nonreactive (“Negative”) Result suggest the following:

3.) Negotiate a specific, concrete, personalized action plan that addresses those behaviors that place the client at risk of HIV exposure; help the client practice relevant skills (e.g., condom use demonstrations, safer sex negotiation rehearsals), and help identify support resources to carry out the plan. Plans for clients with risk-associated behaviors (regardless of HIV status) should stipulate that they agree to refrain from donating blood.

The Post-test Counseling Guidelines for a Client with an HIV Reactive (“Positive”) Result recommend the following:

5.) Negotiate a specific, concrete, personalized action plan to reduce the risk of infecting partner(s) with HIV (and of co-infection with other STIs). Plans for clients with risk-associated behaviors (regardless of HIV status) should stipulate that they agree to refrain from donating blood. Help the client practice relevant skills (e.g., condom use demonstrations, safer sex negotiation rehearsals), and help identify support resources to carry out the plan.

The General Guidelines for Partner Notification and Referral read as follows:

Typical referrals that should be made include:

- Prevention of mother-to-child transmission (PMTCT) and reproductive health services.

12. USAID FP/HIV Integration Technical Guidance (May 2003)

USAID recently produced family planning/HIV integration guidance that takes the form of guiding principles and key technical approaches. While the entire document relates to family planning, several important technical approaches are relevant to the present discussion, as demonstrated by the following:

Include family planning in efforts to prevent mother-to-child transmission (PMTCT). USAID-supported PMTCT interventions should follow the WHO definition of MTCT, which includes the prevention of unintended pregnancies among HIV-infected women. Women participating in PMTCT interventions should have access to family planning counseling and services. Information about the benefits of birth spacing can help HIV positive and negative women plan for future pregnancies.

Include family planning services or referrals with voluntary counseling and testing services. Unprotected sex may lead to sexually transmitted infections, HIV and unintended pregnancies. During VCT, the possibility of pregnancy should also be discussed during pre-test counseling. Referral to FP services and/or provision of non-clinical FP methods should be available for clients who desire an FP method. In high prevalence countries, there may be instances where family planning clinics can offer HIV counseling and either provide VCT or refer clients for testing services.

Dual protection is more than condom use to prevent against unintended pregnancy and HIV/STIs. Dual protection includes not only condom use along with another effective family planning method (dual use), but also mutual monogamy and use of an effective family planning method, abstinence and/or delay of sexual debut.

Promote sound policies for HIV and family planning issues. Policies can contribute to changing social norms on issues related to both HIV and family planning. In addition, analysis of family planning and HIV trends can assist political leaders and policy makers in determining the need for vertical or integrated approaches. Political leaders and effective policies can help to

reinforce the benefits of voluntary family planning in reducing maternal and child mortality and in contributing to HIV prevention.

The guidelines reviewed here cover a period of seven years (1997–2003), and all but one explicitly address family planning. Over time, the guidelines have become more sophisticated in terms of making reference to family planning and addressing the integration of family planning into HIV/AIDS services. For example, the 1997 UNAIDS policies reference reproductive options and safer sex. By 1998, UNAIDS PMTCT and VCT guidelines specifically mention family planning. By 1999, WHO recognizes the importance of family planning as an essential component of the continuum of antenatal care. From 2001 onward, guidelines consistently cite the need for access to family planning information and services. The past seven years show a positive trend in the international community's understanding of the importance of family planning in HIV/AIDS prevention.

Nonetheless, the focus on family planning is primarily a function of providing information on contraceptives and/or referral to family planning services. Indeed, referral to family planning services may place additional burdens on clients, particularly if services are offered in another location; that is, clients might be reluctant to disclose their needs to still another provider. In addition, most of the guidance is directed toward pregnancy prevention among HIV-positive women rather than toward the promotion of improved reproductive health among all women through contraceptive and condom use for pregnancy and STI/HIV prevention.

Analysis of Family Planning Content in National HIV/AIDS Policies and VCT and PMTCT Guidelines

While only 19 African countries have established national HIV/AIDS councils or commissions at the highest government levels, 40 countries have developed national strategic plans or policies addressing HIV/AIDS (UNAIDS and WHO, 2002). The present paper analyzed 16 national HIV/AIDS policies and guidelines. In addition, with some countries recently beginning to develop plans or policies specific to VCT and PMTCT (see Table 1), the paper analyzes nine country-level VCT and seven PMTCT (four in South Africa) policies and guidelines.

Table 1
Policies and Guidelines Reviewed

Country	HIV/AIDS Policy	VCT Guidelines		PMTCT Guidelines	
	Family Planning Mentioned?	Policy?	Family Planning?	Policy?	Family Planning?
Africa					
Botswana	No	Yes (draft)	No	N/A	—
Ethiopia	Yes	N/A	—	Yes	Yes
Ghana	Yes ^A	Yes	Yes	N/A	—
Kenya	No	Yes	Yes	N/A	—
Lesotho	No	N/A	—	N/A	—
Malawi	No	N/A	—	N/A	—
Mozambique	No	Yes	Yes	Yes	Yes
Nigeria	Yes ^A	N/A	—	N/A	—
South Africa	Yes ^B	Yes	Yes	Yes	Yes
Swaziland	No	Yes	No	N/A	—
Tanzania	Yes	Yes (draft)	No	N/A	—
Uganda	Yes ^B	Yes (draft)	Yes	N/A	—
Zambia	No	N/A	—	N/A	—
Zimbabwe	Yes	N/A	—	N/A	—
Other Countries					
Thailand	Yes	N/A	—	N/A	—
Jamaica	Yes	Yes	Yes	Yes	Yes
Key:		Footnotes:			
Yes = family planning referenced		^A Only in the context of equipping family planning clinics with HIV facilities			
No = family planning not referenced		^B Only in the context of PMTCT			
N/A = no policy or could not find policy					

Although the contribution that family planning can make to reducing the spread of HIV is clear, the HIV/AIDS policies reviewed here rarely acknowledged or mentioned a role for family planning. With the exception of Thailand, whose policies mention family planning, any reference to family planning is usually reserved for discussions about equipping family planning clinics with STI/HIV/AIDS counseling facilities, as is the case with Ghana's and Nigeria's policies. Policies in Botswana, Lesotho, Malawi, Mozambique, Swaziland, and Zambia make no reference to family planning.

While not specifically mentioning family planning, Kenya's national policy makes a link between changes in sexual behavior as a result of VCT and the impact of that behavior change on fertility. The policy also identifies men as an important target group in VCT interventions: "Encourage voluntary HIV

testing in all women and men of reproductive age in order to enhance their capacity for decision making regarding their fertility and sexuality.”

Zimbabwe’s policy does not include the phrase “family planning,” although the section on condoms mentions that condoms should be distributed along with information indicating that they can protect against STIs, HIV, and cervical cancer and serve as contraceptives. In the discussion of pregnancy and HIV, Zimbabwe’s policy suggests that individuals and couples should be able to make informed decisions about bearing children.

With Jamaica’s draft national HIV/AIDS policy not available for analysis, the analysis looked at the *Jamaica HIV/AIDS/STI National Strategic Plan 2002–2006*. The plan mentions family planning only once as a part of the objective to make affordable condoms accessible to sexually active men, women, and youth. Specifically, one strategy to meet that objective is “to promote and normalize the use of condoms in addition to another effective family planning method (double protection).”

Uganda’s and South Africa’s comprehensive national policies cite family planning in the context of PMTCT. The Ugandan policy states, “To strengthen sensitization and awareness on MTCT to reduce pregnancies and facilitate informed decision-making among HIV-positive and discordant couples.” Similarly, as one of the objectives in its goal to reduce MTCT, South Africa’s policy states, “Improve family planning services to known HIV-positive women.”

Tanzania’s national policy mentions contraception in the context of PMTCT and emphasizes the importance of reproductive health. The country’s strategy to prevent prenatal transmission calls for “counselling and appropriate contraception for HIV infected women and their partners.” The policy includes information on the gender dimensions of HIV/AIDS and makes reference to reproductive health several times in terms of access to information on reproductive health, raising awareness about the impact of cultural practices on reproductive health, and the need for high-quality reproductive health services. Specifically, it states, “Integrated, quality and user-friendly reproductive health services shall be made accessible to men, women and the youth.” In addition, the policy identifies out-of-school youth as a target group for reproductive health information, noting the following:

The ministries responsible for youth development affairs, in collaboration with Local Government Councils, NGOs and Faith Groups shall develop participatory HIV/AIDS, sexual and reproductive health education programmes for the out of school youth. The youth should be given correct information including the prevention strategies including promotion of correct and consistent use of condoms, abstinence and fidelity, and voluntary counselling and testing. Girls should also be encouraged to avoid unwanted pregnancies. Having been empowered with information, the youth should be encouraged and supported in developing their own strategies. (page 18)

Ethiopia’s national policy highlights family planning in its introduction to the policy and places reproductive health services within a rights-based context as follows:

The Government of the Federal Democratic Republic of Ethiopia hereby demonstrates its commitment to the prevention and control of HIV/AIDS and has issued this national policy on HIV/AIDS. . . aware of the need for women, including women living with HIV/AIDS, to have access to information and services regarding HIV/AIDS and family planning that help them to make reproductive health choices and decisions.

Thailand’s national policy explicitly includes family planning as a major component of its HIV/AIDS policy, which is discussed in the chapter entitled “Health Promotion and Medical Services.” The policy,

as follows, identifies family planning as part of the strategy to support behavior change to decrease the risk of HIV infection:

Developing and upgrading public health services to support more effectively the potential of care-seekers to shape their behavior to avoid the risk of HIV infection. Such services—including treatment for drug addiction and STI, family planning . . .—will be appropriately revised.

The policy then identifies the following specific services for improving the continuum of care for PLHA, and reducing PMTCT:

Improving services, both curative and preventive, for persons living with HIV/AIDS, on a continuing basis by:

- Encouraging the provision of family planning services, accompanied by counseling, for persons living with HIV/AIDS.
- Establishing a systematic approach to reducing the perinatal transmission of HIV, including pre-marital counseling, family planning, caring for HIV-positive pregnant women during pregnancy and after delivery, and advice on care of babies born to HIV-positive mothers.

Thailand's policy also highlights the integration of counseling services as follows:

Promote integration of counseling services in all public and private health facilities. Improve the counseling skills of health staff serving population groups at risk of HIV/AIDS or already infected. Integrate these counseling services within other health programmes, such as family planning, MCH, and primary health care.

Thailand's national policy clearly identifies family planning as an essential component in the prevention and control of HIV. Owing to such emphasis in the country's overall HIV/AIDS policy, it is likely that operational VCT and PMTCT guidelines will adequately emphasize family planning; however, the guidelines were not available for inclusion in the present analysis and may not exist.

Slightly more than half of the policies reviewed in the present analysis include family planning. For the three earliest policies (developed in 1993–1997), it is understandable that the policies make no reference to family planning as its value was not yet embraced for HIV/AIDS treatment and prevention, even at the international level. Of the eight policies developed after 2000, only half reference family planning, and, interestingly, of the two policies developed in 2002, only one mentions family planning. A similar trend might be expected in the international guidelines, that is, over time, policies increasingly recognize the importance of family planning in HIV/AIDS prevention. As HIV/AIDS-related policies are revised or developed, countries have an excellent opportunity to bring the importance of family planning to the policy development table.

National policies are an important first step in ensuring that operational policies (such as VCT and PMTCT guidelines) sufficiently address family planning in the context of HIV/AIDS prevention. Operational policies are “the rules, regulations, codes, guidelines, plans, budgets, procedures, and administrative norms that governments use to translate national laws and policies into programs and services” (Cross et al., 2001). If an overall policy fails to address family planning as a major intervention for HIV/AIDS prevention and control, family planning will more than likely remain inadequately addressed in VCT or PMTCT guidelines.

Family Planning Content in Country VCT Policies

Few countries have yet to set forth VCT guidelines. Of those that have crafted guidelines, six of nine sets of guidelines make some reference to family planning, mostly as a matter to be mentioned in counseling and as a service for referral. Swaziland's VCT policy and Tanzania's policy brief on VCT do not mention family planning. As with its overarching HIV/AIDS policy, Botswana's VCT draft policy does not mention family planning, even under the referral section. Instead, it lists blood donation, PMTCT, STI clinics, and isoniazid preventive therapy as examples of referral centers and services.

Ghana, Jamaica, Kenya, Mozambique, South Africa, and Uganda all make reference to family planning in their VCT guidelines. Like its HIV/AIDS policy, Uganda's VCT policy (draft) is fairly comprehensive and refers to family planning from the point of view of integration. It stresses the need for VCT counselors to assess clients' need for family planning, tuberculosis (TB), and STI services; to provide basic counseling based on clients' identified need(s); and to refer them for further information and care if required. The policy recommends that centers in which VCT is not provided on a daily basis should try, to the degree possible, to ensure that VCT services are aligned with family planning, STI, and TB services to facilitate referrals.

Various sections of Kenya's VCT policy detail family planning services within VCT programs. Building from the country's overall HIV/AIDS policy, which cites VCT programs' potential for motivating behavior change with respect to childbearing, Kenya's VCT policy stresses the need "to incorporate family planning in all VCT counseling sessions, for both HIV-positive and HIV-negative clients." The policy presents clear guidelines for addressing the issue of family planning in all counseling sessions. In the case of pre-test or test-decision counseling, the guidelines recommend a discussion of family planning in light of clients' reproductive intentions. During post-test counseling, in addition to delivering information on family planning methods and services, counselors are encouraged to reinforce the client's current use of contraception if it is an appropriate method and to stress the need for condom use for dual protection. Under the section pertaining to couples counseling, counselors are encouraged to assist couples in identifying appropriate contraceptive methods and to help them explore the implications of test results for their current sexual practices. Finally, the guidelines instruct counselors to discuss the practicality of behavior change to reduce risk.

Kenya's VCT policy also discusses the promotion of dual protection and the importance of providing both men and women with family services at the VCT center. It recommends referrals to facilities where clients can access the full range of family planning methods, including long-term or permanent methods. Kenya's VCT policy clearly emphasizes family planning as a major component of VCT.

Mozambique has developed guidelines to direct its comprehensive HIV/AIDS prevention program. The guidelines address ARV in adults, HIV prevention in health professionals, treatment and prevention of opportunistic infections, and prevention of vertical transmission of HIV; the guidelines also include a *Counselor and Supervisor Manual for VCT Centers*. The *Counselor and Supervisor Manual for VCT Centers* functions as a set of guidelines for the content of VCT counseling and spells out logistic and supervisory requirements. It encourages the use of condoms, focusing on the difficulties associated with their use and providing demonstrations to ensure correct use for both HIV-positive and HIV-negative clients. Counselors are encouraged to provide a "basic orientation to family planning" when carrying out client risk assessment during pre-test counseling. In addition, the policy states that "wherever counseling is carried out, it is important to have regular information sessions about family planning and other reproductive health issues."

It is clear, however, that within the context of VCT, provision of family planning services refers primarily to the promotion of condom use. Guidelines allow for provision of basic information and referral to family planning services. However, for HIV-positive women, the policy outlines specific issues for discussion, including plans for childbearing, the possibility of vertical transmission during pregnancy, how antiretrovirals may prevent transmission, the need to obtain antenatal care, and referral to family planning services to prevent unintended pregnancies.

As noted below, South Africa's VCT guidelines entitled *How to Establish VCT Services: Voluntary Counseling and Testing Guidelines* (2002) mention family planning twice in the context of a component of PLHA care and once in terms of integration:

Follow-up Counselling: In cases of pregnant mothers, implications of the results will need to be explored in the context of the present pregnancy, mode of delivery and future infant feeding choices, family planning and future pregnancies. (page 6)

Continuum of Care: Needs assessment should include the "possibility of linking care for PLHA with STD, Family Planning, TB, MCH and other social services." (page 12)

Continuum of care checklist includes a bullet on integration of HIV/AIDS with existing services and sites: TB, STDs, MCH and family planning clinics. (page 13)

South Africa's VCT guidelines also include the draft *National Policy on Testing for HIV*. The policy's discussion of pre-test counseling notes that such counseling should include discussions on "safer sex and strategies to reduce risk." (page 33)

Jamaica's *Voluntary Counseling and Testing* (no date) guidelines are heavily oriented toward providing explicit details on the process of counseling and testing, including model language for each phase of the counseling process. While the guidelines mention family planning as a component of HIV/AIDS prevention and care, the model counseling language includes no such reference, as the following demonstrates:

Pregnancy and HIV Testing. There are many advantages to a woman's knowing if she is HIV-positive during her pregnancy: She can be counseled and informed about her family planning options after pregnancy. (pages 1-7)

Benefits of VCT to the Couple and Family: Encourages family planning and treatment to help prevent perinatal HIV transmission. (pages 3-5)

Post-Test Session for HIV-Positive Clients: "Explore clients' access to medical and social services: STI examination, TB evaluation, preventive therapy, family planning, perinatal HIV prevention, routine medical care. (pages 5-7)

The guidelines also recognize the special needs of adolescents as follows:

It is often harder for adolescents to obtain condoms and gain access to reproductive health care services. This needs to be taken into account when helping them to develop a realistic risk reduction plan. (pages 2-9)

The *National Guidelines for the Development and Implementation of HIV Voluntary Counselling and Testing in Ghana* (draft) (2003) focus on the steps needed to establish effective VCT services. Even though the guidelines mention family planning, they generally emphasize referral to family planning

services. They note, as follows, that VCT can be delivered in a variety of settings, including integrated sites:

Integrated into general medical outpatient services to the public or as a part of a specialist medical care, e.g., STI clinic, chest clinic, antenatal and family planning services. (page 9)

In the section on pre- or post-test counseling, the guidelines do not specifically mention family planning as a discussion topic in counseling sessions but rather mention it in the context of referral services. However, the section on Services Linked to VCT includes text on family planning services as follows:

Basic family planning information should be incorporated into all VCT counselling sessions, both for HIV+ and HIV-clients. Especially for HIV+ clients, the risks of mother-to-child transmission and the benefits of family planning should be explained. When possible, FP services should be provided at the VCT site. If this is not possible, HIV+ VCT clients should be referred for FP services. Both men and women should be encouraged to access FP services to make informed decisions about contraceptive measures appropriate to their HIV status. Staff of the FP program should be trained in maintaining confidentiality of HIV test results, and the importance of maintaining a respectful attitude to all FP/HIV clients. (page 18)

Section 3.3 on Special Circumstances includes text on “couple counseling and VCT during marriage and/or co-habitation” as follows:

Couple counseling should be encouraged, not only for those planning to get married, but also for those already married or co-habiting who wish to make informed decisions about having children, selection of a family planning method and generally for those who want to work on their relationships and plan their future. . . . [Couples] should be helped to explore the implications of their test results on their relationship, marriage, childbearing, family planning and sex life. (page 29)

Another section on Discordant Couples notes the following:

Relevant and accurate information about HIV/AIDS should be given and couples helped to make informed decisions regarding their health, family planning, childbearing and safer sex. (page 30)

Family Planning Content in Country PMTCT Policies

Of the countries reviewed, we were able to identify PMTCT guidelines only for Ethiopia, Jamaica, Mozambique, and South Africa. All four countries mention family planning in their PMTCT guidelines either indirectly by referring to safer sex or directly by mentioning contraceptive options for pregnant HIV-positive women.

Mozambique’s *Guia para a Prevencao da Transmissao Vertical do HIV* (guidance on the prevention of vertical transmission) are comprehensive in regard to attention to family planning. The guidelines note that women in general should have access to condoms at all service levels. Women have the right to choose the type of contraceptives they prefer, and health providers should always counsel on dual protection. Postpartum women practicing abstinence should receive information on where to obtain contraception when they want it while breastfeeding mothers are encouraged to use barrier methods during intercourse to protect them from infection. The guide does suggest that HIV-positive women should be encouraged to avoid future pregnancies. If they want more children, they should limit the number and consider the risk of transmission to the fetus. The guidance notes that HIV-positive status is not a contraindication to any contraceptive method; however, IUDs should be used with caution. Group

counseling sessions should emphasize condom use to prevent reinfection within HIV-positive couples. Finally, the guidance suggests that postabortion counseling should be used as an opportunity to initiate contraceptive use in addition to reliance on condoms.

South Africa has set forth two national guidelines relating to PMTCT. The first, *Prevention of Mother-to-Child HIV Transmission and Management of HIV Positive Pregnant Women* (2000), frames HIV as a reproductive right, recognizes the importance of primary prevention, and recommends a discussion of family planning in the post-test setting.

Interventions: Preventing new HIV infections: New HIV infection during pregnancy (and breastfeeding) may increase HIV viraemia which will increase the risk of MTCT. Pregnant women should be advised on safer sexual practices, including the importance of correct and consistent condom use. (page 8)

Management: Voluntary Counseling and Testing: VCT must be available to all pregnant women. The benefits to a woman of knowing her status include the ability to make informed choices about infant feeding options, earlier access to care for both mother and child, the opportunity to terminate pregnancy where desired and legal, and the ability to make informed decisions about sexual practices and future fertility. VCT can also promote openness and acceptance of HIV as an important social issue. (page 12)

Issues to consider when counseling HIV positive women:

- Future Fertility Management (page 13)

Post Delivery: Prevention of STDs and family planning: It is recommended to provide barrier methods for the prevention of genital infections and future pregnancies, after comprehensive counseling. Discuss other forms of contraception, including permanent sterilization, both male (vasectomy) and female (tubal ligation). (page 18)

Other Considerations: Human rights, including reproductive rights and the rights to informed choices and confidentiality, should be respected. This means that the social environment must enable women and families to make informed choices and cope with the choices they make. (page 19)

South Africa's second set of guidelines, *Feeding of Infants of HIV Positive Mothers* (2000), notes the importance of access to family planning as follows:

Since the primary purpose of counseling and testing is to encourage informed decision-making and behavior, it is very important that individuals have access to the necessary services they need. These may include family planning (to avoid pregnancy), condoms to practice safer sex during pregnancy and breastfeeding, primary care services for HIV care for adults and children and ongoing counseling services for individuals needing further support. (page 14)

The Provincial Administration of the Western Cape, South Africa, produced *Prevention of Mother to Child Transmission of HIV: Full Protocol* (2002) to guide health workers implementing PMTCT in the Western Cape Province. The protocol mentions safer sex twice in the context of post-test counseling and explicitly mentions family planning once on a referral form. For HIV post-test counseling, the protocol calls for the following:

If a woman tests HIV-negative, she receives post-test counseling focused on how to maintain her HIV-negative status, with a focus on her health, safer sexual practices, and the high risk of transmission to her baby should she become infected during pregnancy or breast-feeding. The

window period should be explained once more and she should receive routine antenatal care. (page 5)

If a woman tests HIV-positive. . .the newly diagnosed HIV-positive woman is also provided with: information about safer sex during pregnancy and the long term. (page 5)

The Provincial Administration of the Western Cape, South Africa, also produced *Breastfeeding and HIV: An Information Booklet for Health Workers in South Africa* (2002). The document mentions family planning as follows in terms of preventing pregnancy in HIV-positive women and preventing infection during pregnancy:

The best way to avoid MTCT is to prevent women of reproductive age from becoming HIV-infected by targeting and discouraging high-risk behaviour or to provide good family planning so that HIV-infected women can avoid pregnancy. HIV-uninfected women who are breastfeeding their infants should avoid HIV high-risk behaviour and take precautionary steps (e.g., using condoms) to avoid becoming HIV infected. (page 8)

Unprotected sex during pregnancy and lactation not only places a woman at risk of HIV but also increases the risk to her infant. It is important for all breastfeeding women to avoid high-risk behaviour and take steps (e.g., use condoms during sexual intercourse) to prevent becoming infected or re-infected with HIV while they are breastfeeding. (page 11)

Jamaica's *Prevention of Mother to Child Transmission of HIV (PMTCT): Implementation Guidelines for Health Care Workers* (2003) not only mentions the importance of family planning but also names specific contraceptive methods and emphasizes the importance of informed reproductive health choices. For primary prevention, the document recommends the following:

Promoting use of an effective family planning method (e.g., tubal ligation, Depo Provera, Oral Contraceptives or Norplant). (page 2)

For secondary prevention, the document recommends the following:

Ensuring that HIV-infected females and their partners make informed reproductive choices. (page 2)

Guidelines on pre- and post-test counseling emphasize family planning as follows:

Pre- and post-test counseling goals: Make informed choices about contraception and condom use. (page 4)

Pregnant women who test HIV-negative: Understand and maintain safer sex behaviour (including abstinence, partner reduction and condom use) in order to prevent HIV infection in the future. (page 5)

Pregnant women who test HIV-positive: Make informed choices about sexual behaviour (condom use) and future fertility, including tubal ligation or other long-term method such as Depo Provera, Norplant etc. (page 5)

Positive result: Discuss obtaining needed medical care, family planning options, testing for sexually transmitted diseases and TB. Discuss how to reduce her risks and protect others in the future. (page 7)

Post-delivery follow-up in HIV-positive mother: Counselling at postnatal clinic about family planning methods and choices inclusive of tubal ligation and Norplant. (page 14)

Other pregnancy outcomes: Long-term contraceptive and counseling should be offered to the mother.

The *National Guidelines on the Prevention of Mother-to-Child Transmission of HIV in Ethiopia* (2001) are comprehensive and include two main sections, one on technical strategies for PMTCT and one on program management of PMTCT. Technical strategies for PMTCT include care for the mother, care for the infant, infection prevention measures, communication strategies, home-based care and social support, and program components by level of care. The second section on program management includes information on planning PMTCT programs, drugs and formula supply management, quality care assurance, human capacity building and training needs, monitoring and evaluation, and management information systems. The guidelines are presented in a framework of protecting reproductive rights and cite family planning services as one of the seven main components of a PMTCT package. Under Section I: Technical Guidelines for PMTCT, the guidelines for planning a PMTCT program call for the following:

Consider respecting women's rights, and particularly:
On deciding on child bearing: the number, the timing, etc. by providing access to family planning information and methods. (page 5)

Furthermore, the guidelines include the following:

Program planners should keep in mind that any strategy to implement PMTCT should be an integral part of promotion of existing maternal and child services in any locality. (page 6)

Ethiopia's guidelines emphasize family planning services as one of the seven program components to be included in the PMTCT planning process. In the summary of PMTCT program components by level of care, the guidelines state that an expected task at the health post level is to "counsel and provide FP to all women in reproductive age," yet they do not mention family planning at the community, health center, rural hospital, regional hospital, and referral hospital levels. Under maternal and fetal care, the introductory paragraph states the following:

According to UNAIDS and WHO, prevention of MTCT can be commenced by reducing transmission of the virus to women in the reproductive age group; prevention of pregnancy through use of FP services, and termination of pregnancy in HIV positive women where the law of the land permits. (page 9)

Under preconception care, the guidance notes the following:

Prevention of pregnancy by use of family planning methods for those who do not want more children shall be given due emphasis particularly in countries like ours where safe abortion services are restricted by law. (page 11)

The guidelines note the following benefit of VCT: "Knowledge of her HIV status enables the woman to take decision on continuation of the pregnancy and on future fertility." (page 12) However, the document does not list family planning as a component of pre- or post-testing; the topic arises only as an issue to be discussed when HIV-positive pregnant women receive counseling. The section on postpartum care, however, includes a paragraph on contraception and condom use as follows:

Because of the medical complications and the extra cost discussed above, women with HIV shall be given contraceptive counseling and helped to make an informed decision. In addition, those mothers who elected not to breastfeed shall be informed to resume their chosen method as soon as possible since the contraceptive benefit of breastfeeding is absent. Condom use shall be encouraged postpartum as well. (page 19)

As noted below, the section on infant feeding options mentions family planning as an issue to be considered for replacement feeding:

Women who do not breast feed lose the child spacing benefit of breastfeeding. It is essential that HIV positive women have access to appropriate family planning methods. (page 22)

The communication strategy section notes as follows that family planning is one of the seven issues that should be addressed through a PMTCT communication strategy:

Mothers should be taught not to get pregnant once they are HIV infected and various FP methods should be used. Particularly use of condoms should be advocated for its dual purpose of FP and prevention of STIs. (page 29)

The section on home-based care and social support to mothers and children living with HIV/AIDS, indicates that the following service, among others, should be offered:

... information and education on STIs/HIV/AIDS and provision of condoms in order to promote responsible/safe sexual behavior—for family planning and prevent the spread of HIV/AIDS and other STIs. (page 30)

Two-thirds of the VCT guidelines and all of the PMTCT guidelines make reference to family planning. The VCT guidelines recognize the importance of counseling in family planning and of making appropriate referrals. Overall, the PMTCT guidelines are even more explicit in addressing clients' family planning needs, a particularly important consideration given that clients seeking PMTCT are sexually active and fertile. Of the VCT guidelines reviewed here, the comprehensive guidelines prepared by the governments of Ghana, Kenya, and Uganda succeed in highlighting family planning through the lens of integration, dual protection/dual method use, or information for serodiscordant couples. Clearly, these three countries recognize the importance of family planning in the VCT setting. It is also encouraging that Mozambique's and Jamaica's counseling guidelines refer to clients' family planning needs.

The four national PMTCT guidelines, all developed between 2000 and 2003, emphasize reproductive choice and rights and highlight the importance of primary prevention of HIV. South Africa's national guidelines on the feeding of infants of HIV-positive mothers note the importance of access to family planning but are not as comprehensive as the country's other guidelines. Similarly, the regional guidelines developed for Western Cape Province are not as explicit as the national guidelines, but they nonetheless recognize family planning as an important referral service.

That most country PMTCT guidelines call for family planning services, as compared with slightly more than half of national HIV/AIDS policies, is an encouraging trend. As with the national policies, it is critical that the revision of existing policies or development of first-time policies includes provisions for family planning services. The following section identifies gaps that might help policy writers develop comprehensive and explicit guidelines.

Gaps in the Policies and Guidelines

This analysis indicates the need for a stronger emphasis on family planning information and referral in most national HIV/AIDS policies and in most VCT and PMTCT guidelines. The discussion below identifies a series of policy gaps that need to be addressed to ensure that family planning is a major component of VCT and PMTCT services.

Stronger Linkages with Maternal and Child Health/Family Planning Departments. A deficiency in most policies with respect to the provision of family planning services is the failure to acknowledge the need for collaboration between maternal and child health/family planning departments and HIV/AIDS departments. In many countries, maternal and child health/family planning and national HIV/AIDS departments operate two vertical programs, often with little overlap at the national and local levels. Guidelines and strategic plans should pinpoint the types of collaboration needed between the departments in order to promote effective family planning referral mechanisms. Training manuals should be developed with adequate family planning training for HIV/AIDS counselors.

Greater Emphasis on Human Rights and Reproductive Rights. Many country policies discuss HIV/AIDS within a human rights context. Countries such as Ethiopia, Lesotho, Tanzania, and Zambia address the issues of discrimination, mandatory testing, partner notification, and willful transmission of HIV. While recent studies have highlighted the stigma and discrimination faced by women in making decisions related to sexual activity and childbearing (ICW, 2002; ICRW, 2002; Jere, 2002), most policies reviewed here lack a gender and reproductive rights-based perspective. Such a perspective emphasizes the right to marry and have a family, the rights of couples and individuals to decide freely and responsibly about the number and spacing of children, and the right to make decisions free from discrimination, coercion, and violence. Only Tanzania's national HIV/AIDS policy and Ethiopia's and South Africa's PMTCT guidelines touch on reproductive rights, including the importance of informed choice and confidentiality.

Stronger Gender Perspective. The present policy assessment reveals that HIV/AIDS policies lack a strong gender focus. VCT policies need to incorporate critical gender issues, such as couples counseling and male involvement. "It is common for couples to avoid discussing the very aspects of their relationship that are most likely to lead to unsafe sex. Barriers to communication are exacerbated due to the often overwhelming fear of HIV transmission, illness, and loss. Major issues that couples often wrestle with include differences in sero-status 'identity'; difficulties associated with planning; fear of HIV transmission; decisions about pregnancy, parenthood, and childrearing; fear of abandonment; caretaking concerns; and sadness, guilt, and rage" (Remien, 1999). VCT programs for pregnant women can benefit from the involvement of men. Evidence from studies suggests that, when women test HIV-positive and their male partners are not tested, women often bear the blame for introducing the infection. Such unfounded blame can lead to conflict, abandonment, and even violence (Feldman et al., 2002). Couple pre- and post-test counseling offers significant benefits for addressing risk assessment and risk-reduction planning, particularly for women in countries characterized by substantial gender inequity. In addition, it is well acknowledged that targeting couples for VCT is cost-efficient (Sweat et al., 2000).

While Kenya's national strategic plan recognizes the importance of a gender focus, the plan does not specify gender-sensitive strategies. Recognizing the enormous impact of HIV/AIDS on women as compared with men, in 2001 the National AIDS Control Council (NACC) of Kenya established the Technical Sub-Committee on Gender and HIV/AIDS Task Force to analyze gender and HIV/AIDS and develop a set of guidelines for use by policymakers and program managers to ensure that men, women,

boys, and girls benefit from the national HIV/AIDS program. The task force identified major gaps in the strategic plan and commissioned two field studies to investigate gender vulnerabilities to HIV/AIDS. In November 2002, the government of Kenya published *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan, 2000–2005* (Government of Kenya, 2002).

Emphasis on Choice in Fertility for HIV-Positive Women. As ratified in a number of international agreements, including the ICPD Program of Action, all women, including HIV-positive women, have the right to make a free and responsible decision on the number and spacing of children. As a practical matter, however, the provision of family planning counseling to HIV-positive women is often not a priority. Evidence shows that, in direct contravention of their reproductive rights, HIV-positive women are often counseled to terminate a pregnancy or to avoid bearing children (de Bruyn, 2002). Furthermore, HIV-positive women have special needs that should be taken into consideration. Some women will want to end childbearing and will therefore need family planning counseling that enables them to make informed decisions on the best contraceptive options. Others desire to bear children and must be carefully counseled to make informed choices while understanding the implications of possible vertical transmission. Such women could significantly benefit from additional support and care services such as PMTCT programs, STI treatment services, and basic health care provision, among others. Successful programs can provide services to offer better options to women. For example, a study in Rwanda worked with HIV-positive women who had already received VCT and subsequently increased condom use but continued to exhibit a high rate of pregnancy. The intervention increased the women's access to information on hormonal contraceptives, which led to a 16 to 24 percent increase in the use of these methods. In the year following the intervention, only 9 percent of HIV-positive women became pregnant as compared with 22 percent in the previous year, when hormonal contraceptives were not provided (King et al., 1995, cited in De Zoysa and Adjorlolo-Johnson, 2001).

Little is known about the effects of antiretroviral therapies (ARTs) on the fetus and newborn. Clinical trials in human pregnancy have been conducted for several drugs, including zidovudine and nevirapine. The trials showed no increase in birth defects between the drug and placebo groups. However, certain ARVs suggested evidence of toxicity for pregnant women and fetuses (Public Health Service Task Force, 2003; Newell, 2001). Family planning can be recommended for HIV-positive women until more is understood about the short- and long-term benefits and risks of ARVs.

Emphasis on the Timing of Family Planning Counseling. The country policies considered here indicate a lack of consistency in specifying the point at which family planning counseling should be offered in conjunction with HIV/AIDS counseling. For example, the Mozambique VCT guidelines emphasize the provision of basic information during pre-test counseling, whereas PMTCT guidelines for the Western Cape Province of South Africa stress the importance of family planning counseling as part of post-test counseling. The Kenya VCT and Jamaica PMTCT guidelines stress family planning in all counseling sessions. Kenya's VCT policy also delineates the types of discussions that counselors should conduct with clients in the event of either negative or positive HIV test results. The findings from an assessment of VCT centers in Kenya indicate that the majority of supervisors (>50 percent) thought that family planning should be discussed in post-test counseling while more counselors thought family planning should be discussed in pre-test counseling. Most clients indicated a preference for receiving family planning information in post-test counseling (Reynolds, Liku, and Maggwa, 2003). Policies and guidelines should emphasize the need to discuss family planning at several points during the VCT intervention.

Dual Protection and Dual Method Use. While some of the country guidelines reviewed here refer to family planning, only Kenya's VCT guidelines and Ethiopia's PMTCT guidelines emphasize dual protection or dual method use. Condoms are the only method available to help prevent HIV and STIs among couples in which one partner is HIV-positive; however, condom use is not the most effective

method for preventing pregnancy. Most methods that are effective for preventing pregnancy—such as hormonal methods and IUDs—are not effective for preventing HIV or STIs. Although dual protection seems a worthy objective (prevent pregnancy and prevent HIV/STIs), counselors in VCT clinics must weigh clients' individual priorities—preventing pregnancy versus preventing HIV/STIs—and take into consideration additional factors such as cost and user compliance with dual protection and dual method use. Men should be counseled on the importance of using condoms, particularly with nonregular partners (USAID, 2003). In addition, clients can be counseled on abstinence or mutual monogamy with an uninfected partner along with use of family planning methods (USAID, 2003). Policies should stress the need to train family planning providers and counselors at VCT sites in the proper assessment of clients' sexual risk behavior and plans for pregnancy (IGWG, 2003).

Further Investment and Stronger Linkages to Care and Support Programs. Only South Africa's VCT guidance places HIV and family planning services in the context of a continuum of care. Guidelines need to establish clear linkages between health services and care and support programs, such as social services.

Broader Participation in Policy Development. Broader participation in the policy development and review process will help ensure that policies and guidelines adequately address client needs (Stover and Johnston, 1999). For example, the Kenya VCT guidelines effectively address family planning in the context of HIV/AIDS. The guidelines grew out of a highly participatory process that called for a series of workshops and study tours to other countries. In addition to a technical working group, important stakeholders in the policy development process included international donors, international nongovernmental organizations, the Network of People Living with HIV/AIDS (NEPHAK), the National Public Health Laboratory, and the Kenya Association of Professional Counselors. Broad participation early in the policy process can help ensure that policies "give a voice to all concerned" (Stover and Johnston, 1999).

Operational Challenges. The integration of family planning into VCT and PMTCT services poses significant operational challenges, including staff turnover, supply shortages (such as a lack of contraceptives, needles, syringes, alcohol swabs, and clinical/surgical instruments), equipment shortages, time shortages, client-flow issues, and weaknesses in infrastructure. Human resources is a particular problem. For example, in Mozambique, due to a shortage of health personnel, the National STI/HIV/AIDS Program began recruiting retired personnel and laypersons as counselors (Van Rooyen and Solomon, 2002). It would be ideal for HIV counselors to provide comprehensive family planning information to clients; however, the delivery of such services requires a significant investment in training adequate numbers of counselors and reviewing materials to ensure adequate emphasis on family planning as part of HIV counseling. If the training of counselors in family planning is not feasible, it is essential to strengthen referral and recordkeeping systems as a prerequisite to addressing clients' family planning needs. To the degree possible, family planning services should be provided in the same facility that delivers HIV services; moreover, family planning services should be emphasized as a key referral point in VCT and PMTCT. Service sites have different requirements in terms of the supplies, equipment, and laboratory facilities needed for VCT, PMTCT, and FP. For example, if a VCT site does not have clinical or surgical instruments, the provision of clinical methods of family planning, such as an IUD or sterilization, would not be feasible (Foreit et al., 2002). Research on operational policy barriers can identify site-specific issues and provide options for removing barriers.

Adolescents as a Specific Target Group. Adolescents need to be specifically targeted for the receipt of VCT services (Boswell and Baggaley, 2002), but only Jamaica's VCT guidelines highlight the special needs of young persons. Even though sexual activity often begins during adolescence, several conditions militate against adolescents' use of VCT services: guidelines on parental consent for testing and the disclosure of results for clients under the age of legal consent, the lack of awareness of services, and the absence of youth-friendly services. At the same time, health workers have been slow to address the

specific needs of both infected and uninfected youth, and most countries' training of health care workers in communicating with adolescents has been poor. By contrast, the Kara Counseling and Training Trust in Zambia recognizes that, if it is to attract young people, it must adopt adolescent-specific strategies such as ensuring the active participation of youth in program design, involving youth in programs as peer counselors, and using outreach activities to promote testing and counseling among youth (WHO/UNAIDS et al., 2001). Research conducted in Kenya and Uganda shows that VCT programs need to be upgraded to ensure that VCT sites attract vulnerable groups, such as single men, adolescents, and youth (Horizons, 2001). Country guidelines should call for the following improvements: elimination of parental consent for VCT, enhanced training skills for providers working with youth, increased confidentiality of the testing process and results disclosure, reduced price of testing, improved referral systems, and expanded outreach to youth through schools and youth groups.

To date, few countries have developed explicit PMTCT and VCT guidelines. Of the existing guidelines, they exhibit variation in the extent to which they address family planning. Some of the guidelines mention the provision of information and contraceptives while others refer clients to other sites for these services. But what is the feasibility of integrating family planning into VCT and PMTCT services? Should and can integrated services be effectively offered in VCT and PMTCT settings? What are the operational barriers to family planning provision in the HIV setting? The next step of this research is to conduct in-depth country studies to help answer some of these questions.³

³ POLICY plans to conduct in-depth studies in several countries to investigate barriers to the provision of family planning in conjunction with VCT and PMTCT services, the extent to which family planning services have been and can be integrated into VCT and PMTCT programs and services, and the specific needs of service providers and clients in providing and gaining access to these services.

Appendix 1: International Guidelines

1. UNAIDS Policy on HIV Testing and Counseling (1997)
2. UNAIDS/UNICEF/WHO HIV and Infant Feeding: A Policy Statement (1997) included in HIV and Infant Feeding: Guidelines for Decision-makers (1998)
3. UNAIDS/UNICEF/WHO HIV and Infant Feeding: Guidelines for Decision-makers (1998)
4. UNAIDS Mother to Child Transmission of HIV: A Technical Update (1998)
5. UNAIDS Counseling and Voluntary Testing for Pregnant Women in High HIV Prevalence Countries: Elements and Issues (2001)
6. WHO Voluntary Counseling and Testing for HIV Infection in Antenatal Care: Practical Considerations for Implementation (1999)
7. WHO New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications: Conclusions and Recommendations (2001); WHO Technical Consultation on Behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV
8. CDC Revised Guidelines for HIV Counseling, Testing, and Referral (2001)
9. CDC Revised Recommendations for HIV Screening of Pregnant Women (2001)
10. USAID Prevention of Mother-to-Child Transmission of HIV in Africa: Practical Guidance for Programs (2001), prepared by the SARA Project
11. Model Guidelines for Voluntary Counseling and Testing: A SADC Priority Policy Guideline Document (2002)
12. USAID FP/HIV Integration Technical Guidance (May 2003)

Appendix 2: National HIV/AIDS Policies

1. *Botswana National Policy on HIV/AIDS* (1993), Ministry of Health, Government of Botswana
2. *Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia* (1998), Ministry of Health, Federal Democratic Republic of Ethiopia
3. *Draft National HIV/AIDS and STI Policy Document* (2000), National AIDS/STDs Control Program, Ministry of Health, Republic of Ghana
4. *Jamaica HIV/AIDS/STI National Strategic Plan 2002–2006* (Draft) (2002), Ministry of Health, Government of Jamaica
5. *Sessional Paper No. 4 of 1997 on AIDS in Kenya* (1997), Ministry of Health, Government of Kenya
6. *Policy Framework on HIV/AIDS Prevention, Control, and Management* (2000), Government of Lesotho
7. *Malawi's National Response to HIV/AIDS for 2000–2004: Combating HIV/AIDS with Renewed Hope and Vigour in the New Millennium* (2000), Government of Malawi
8. *Medium Term Plan II (1994–1998) of the National Control Programme against STD/AIDS in Mozambique* (1995), Maputo, Republic of Mozambique
9. *National Policy on HIV/AIDS/STIs Control* (1997), National HIV/AIDS/STIs Control Programme, Ministry of Health, Government of Nigeria
10. *HIV/AIDS and STDs: Strategic Plan for South Africa, 2000–2005* (2000), Republic of South Africa
11. *Policy Document on HIV/AIDS and STD Prevention and Control* (1998), Government of Swaziland
12. *National Policy on HIV/AIDS* (2001), Prime Minister's Office, Dar es Salaam, United Republic of Tanzania
13. *The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/01 to 2005/06* (2000), Republic of Uganda
14. *National HIV/AIDS/STI/TB Policy* (2002), Ministry of Health, Republic of Zambia
15. *National Policy on HIV/AIDS for the Republic of Zimbabwe* (1999), Government of Zimbabwe
16. *National Plan for Prevention and Alleviation of HIV/AIDS: 1997–2007* (1997), Bangkok, Thailand, National AIDS Committee

Appendix 3: National VCT and PMTCT Guidelines

National VCT Guidelines

Botswana

1. Voluntary HIV Counseling and Testing in Botswana: Policies and Procedures Manual (Draft) (2000)

Ghana

2. National Guidelines for the Development and Implementation of HIV Voluntary Counselling and Testing in Ghana (Draft) (2003), Ghana AIDS Commission, Republic of Ghana

Jamaica

3. Voluntary Counseling and Testing. N.d.

Kenya

4. *National Guidelines for Voluntary Counseling and Testing* (2001), National AIDS and STD Control Programme, Ministry of Health, Republic of Kenya

Mozambique

5. Aconselhamento e Testes Voluntarios–ATV: Manual de Conselheiros e do Supervisor dos Gabinetes de ATV (2001), Republica de Mocambique, Ministerio da Saude, Programa Nacional de Controle DTS/SIDA

South Africa

6. *How to Establish VCT Services: Voluntary Counselling and Testing Guidelines* (2002), CDC, AIDS Helpline, and Ministry of Health, Government of South Africa

Swaziland

7. VCT in Swaziland. N.d.

Tanzania

8. *Voluntary and Counseling and Testing Is Key to HIV/AIDS Prevention and Care. Tanzania Policy Brief (Draft)*. N.d.

Uganda

9. Uganda Policy Guidelines for Voluntary Counseling and Testing of HIV (Draft) (2003), Ministry of Health, Republic of Uganda

National PMTCT Guidelines

Ethiopia

1. *National Guideline on the Prevention of Mother-to-Child Transmission of HIV in Ethiopia* (2001) Ministry of Health, Disease Prevention and Control Department, HIV/AIDS and Other STDs Prevention and Control Team in collaboration with the National HIV/AIDS Prevention and Control Secretariat (NACS)

Jamaica

2. Prevention of Mother-to-Child Transmission of HIV (PMTCT): Implementation Guidelines for Health Care Workers (2003) National HIV/STI Programme, Ministry of Health Jamaica

Mozambique

3. *Guia para a Prevencao da Transmissao Vertical do HIV* (2002), Republica de Mocambique, Ministerio da Saude, Programa Nacional de Controle DTS/SIDA

South Africa

4. Prevention of Mother-to Child HIV Transmission and Management of HIV Positive Pregnant Women (2000), HIV/AIDS Policy Guideline, Department of Health, Government of South Africa
5. *Feeding of Infants of HIV-positive Mothers* (2000), HIV/AIDS Policy Guideline, Department of Health, Government of South Africa
6. *Prevention of Mother-to-Child Transmission of HIV: Full Protocol* (2002), Department of Health, Provincial Administration of the Western Cape, South Africa
7. Breastfeeding and HIV: An Information Booklet for Health Workers in South Africa (2002), Provincial Administration of the Western Cape, South Africa

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